

**COMPLETE ALL SECTIONS**

COMMERCIAL ACTIVITY  
AGRICULTURAL ACTIVITY

ISSUING AGENCY	NUMBER	EXPIRATION DATE
_____	_____	_____

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**5. AUTHORIZED INDIVIDUALS**

A) Person to be responsible for supervising the use of syringes and needles

Name \_\_\_\_\_ Title \_\_\_\_\_

B) List the individuals responsible for the custody of syringes and needles

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

(Attach additional sheet with names and titles if necessary)

C) Specify location where syringes and needles will be used \_\_\_\_\_

\_\_\_\_\_

D) Purpose for the use of syringes and needles \_\_\_\_\_

\_\_\_\_\_

E) Indicate the maximum annual usage of Syringes \_\_\_\_\_ Needles \_\_\_\_\_

**6. SECURITY OF SYRINGES AND NEEDLES**

A) Identify type of cabinet to be used for storage of syringes and needles \_\_\_\_\_

B) Identify location of cabinet \_\_\_\_\_

C) Identify type of locks to be used \_\_\_\_\_

**7. CERTIFICATE OF APPLICANT**

Under the penalties of perjury, I affirm that the statements herein are true and that I will comply with  
NYCRR Title 10, Section 80.133 of New York State Rules and Regulations.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Mail completed form to: Bureau of Narcotic Enforcement  
433 River Street, Suite 303  
Troy, NY 12180  
(518) 402-0707